

Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan 2003-2009



December 2003





Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010

Richard C. Dunn
Director



Bob Holden
Governor

December, 2003

Dear Colleague,

This document, *Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan 2003-2009*, is a product of the collective thinking of hundreds of state and local tobacco control partners in Missouri.

The strategies in this plan reflect evidence-based approaches for reducing tobacco use among youth, increasing quitting among youth and adults, and decreasing exposure to secondhand tobacco smoke. These are the overall goals of a comprehensive program. Evidence of the effectiveness of these strategies is determined through the evaluation of programs in states that have implemented comprehensive tobacco use prevention programs. The combination of implementing fully funded prevention programs and adopting tobacco control policies such as increasing the price of tobacco products and banning smoking in public places significantly reduces tobacco use.

Measurable outcomes and objectives are established to gauge progress in achieving the overall goals for the Missouri program. Baseline measures for the outcomes, objectives and targets are set. A process by which changes in measures are tracked has been developed and will provide important information about progress over time.

It is hoped that those working to reduce tobacco use and exposure to secondhand smoke in Missouri will embrace the strategies in this plan, and will take action to implement them.

Sincerely,

A handwritten signature in black ink that reads "Paula F. Nickelson".

Paula F. Nickelson, Director
Division of Community Health

Missouri Comprehensive Tobacco Use Prevention Program Strategic Plan 2003-2009 December 2003



*Division of Community Health (DCH)
Section of Chronic Disease Prevention
and Health Promotion (CDPHP)*

Health Promotion Unit (HPU)

*Missouri Tobacco Use Prevention Program
1-866-726-9926 (toll-free)
www.dhss.mo.gov/SmokingAndTobacco*

Richard C. Dunn, Director, DHSS

Paula F. Nickelson, Director, DCH

Deborah Markenson, M.S., R.D., Administrator, CDPHP

Sherri G. Homan, R.N., Ph.D., Administrator, Office of Surveillance, Evaluation, Planning & Health Information

Janet S. Wilson, M.P.A., M.Ed., Chief, HPU

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Hearing-impaired citizens' telephone 1-800-735-2966.

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Rex Archer, M.D., M.P.H., & Pat Morgester, M.P.H., Kansas City Health Department

Mari Ann Bahr, M.Ed., Department of Elementary and Secondary Education

Deborah Boldt, M.P.A., Missouri Partnership on Smoking or Health

Bonnie Bowles, Missouri Association of Osteopathic Physicians

Ross Brownson, Ph.D., Prevention Research Center- St. Louis University

Jim Caccamo, Ph.D., State Board of Senior Services

C. William Chignoli, M.A., M.Div., La Clinica, St. Louis

Jim Davis, Ph.D., University of Missouri-Columbia

Dalen Duitsman, Ph.D., Ozarks Public Health Institute, Southwest Missouri State University, Springfield

Edwin Fisher, Ph.D., Washington University

Ollie Fisher, D.M.D., State Board of Health

Jay Goodman, American Cancer Society-Heartland Division

Belinda Heimericks, M.S.(N), R.N. Missouri Nurses Association

Tom Holloway, Missouri State Medical Association

Bonnie Linhardt, American Heart Association-Heartland Affiliate

Jacob Lippert, D.D.S., Missouri Dental Association

Bernard Malone, M.P.A., Kansas City Health Department

Ann Mangelsdorf, Program Services, March of Dimes

Sherry Maxwell, Lincoln University Cooperative Extension

Ross McKinstry, M.S.P.H., Randolph County Health Department

Viviane McKay, M.P.H., & Jacquelynn A. Meeks, Dr.P.H., St. Louis County Department of Health

Melba Moore, M.S., & Bruce Yampolsky, M.P.A., City of St. Louis Department of Health

Lori Pickens, M.H.A., American Lung Association, Eastern Missouri

Leslie Porth, R.N., M.P.H., Missouri Hospital Association

Rev. B. T. Rice, M.I.S.S.I.O.N. NOW, St. Louis

Tricia Schlechte, M.P.H., B.S.N., Director's Office, DHSS

Steve Shimmens, Missouri Division of Liquor Control

Pam Victor, C.P.A., Division of Medical Services

Charles Williams & Jamie Scott, Missouri Department of Mental Health

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In Missouri, tobacco use . . .

- is responsible for more than 10,300 deaths each year
- causes an estimated 1,200 deaths annually due to exposure to secondhand smoke
- results in overwhelming health care, disability, lost productivity and revenue—\$415 million in Medicaid costs, \$1.7 billion in total medical expenditures and \$2.17 billion annually in tobacco-caused productivity losses
- is reported by almost one in three Missouri high school students (30.3%)
- is estimated to cause 1,500 Missouri youth to become regular smokers each month
- will cause approximately half of those youth that continue to smoke to eventually die from smoking-related illness
- is reported by 26.5% of adults in Missouri making it among the highest adult smoking rate in the U.S. (2002)
- is reported at much higher levels for adults with less education (37.3% of those with less than a high school education compared to 16.2 % of college graduates)
- is reported at higher levels for those that have incomes less than \$15,000 (36.3%)
- is taxed at one of the lowest rates in the country (17 cents/pack—Missouri's ranks 44th in tax per pack of cigarettes)



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Missouri's Story

Public health officials are faced with many challenges in our efforts to improve the health of all Missourians. One of the biggest challenges is to reduce the burden that tobacco use is placing on the health and economy in our state. Tobacco use in Missouri is responsible for more than 10,300 deaths each year ¹, which equates to the loss of 33 valued Missourians every day. Those dying are our mothers, brothers, neighbors and friends who are prematurely losing on average 13.3 years of their life ² due to tobacco's addictive and health compromising properties.

The magnitude of the tobacco use problem has prompted the Missouri public health and tobacco use prevention community to unify efforts to compile a comprehensive plan that addresses this enormous problem. This plan outlines specific actions that we can take to decrease tobacco use and lower the resultant health problems and costs attributed to tobacco use. The Steering Committee adopted Missouri's "show-me" philosophy to select and tailor successful, best practices from other states. This process assured Missouri a well-designed plan to tackle our unique and challenging issues and needs. The current social norms have led Missourians to accept tobacco use but this tolerance and these norms must be challenged and changed in order to protect the public's health.

It is well established that statewide tobacco-use prevention and cessation programs prompt sharp reductions in smoking levels among both adults and children. Immediate savings have been realized in states targeting efforts to pregnant women who smoke.³ The long-standing tobacco programs in California and Massachusetts have been shown to save up to \$3 in health costs for every dollar spent on prevention.⁴ Tobacco use prevention efforts have also been shown to directly reduce state Medicaid program expenditures.



Effective strategies are incorporated into the plan to point us in the right direction for achieving three major goals:

- 1. Prevent tobacco use initiation among young people.**
- 2. Promote quitting among young people and adults.**
- 3. Eliminate exposure to second hand tobacco smoke.**

For the average state, more than 14% of all smoking-caused health care expenditures within its borders are paid for by the state's Medicaid program.⁵

Funding from the tobacco Master Settlement Agreement (MSA) and tobacco tax revenue is not used for tobacco control and prevention efforts, which results in Missouri's rank of 51 compared to other states' use of MSA and tobacco tax funds.⁴ [The Centers for Disease Control and Prevention (CDC) estimates that Missouri's annual cost of an effective, comprehensive tobacco prevention program would range from \$32.8 to \$91.4 million.⁶] There are compelling arguments for Missouri to begin sustainable funding for tobacco use prevention and cessation efforts to implement this plan. The evidence is clear that, even in these difficult budget times, tobacco use prevention is one of the smartest and most fiscally responsible investments that the state can make. Tobacco use prevention is both good public health policy that will reduce the burden of tobacco use and good fiscal policy that will help solve the state's budgetary challenges by reducing the tremendous amounts spent to treat smoking-caused diseases under Medicaid. This plan lays the foundation and outlines critical steps that we can take to lessen the burden that tobacco use causes.

Partners Unite to Design Comprehensive Approach

Strong Missouri partners have long been active in the movement to prevent and reduce tobacco use. In anticipation of receiving Master Settlement Agreement funds and recognizing the need to demonstrate measurable results, the partners embarked on a process (Appendix A) to create a comprehensive tobacco use prevention strategic plan that would provide the overall framework for coordination of evidence-based interventions in Missouri.

The Partners

A comprehensive approach to tobacco use prevention assures integration of all aspects of both prevention and cessation. If a comprehensive program is to have sustainability and maximum effectiveness, it must integrate broad-based efforts with existing and new partners. Coordination at a statewide level requires a plan to be developed through a state-level committee. A steering committee of tobacco use prevention experts, partner organizations, and stakeholders was convened to create Missouri's strategic plan.

The Missouri Statewide Tobacco Steering Committee included representatives from Missouri Department of Health and Senior Services (DHSS) and other state agencies; local public health agencies; community and voluntary health agencies, partnerships and coalitions; medical, dental and nursing associations; universities and colleges; health care providers and faith-based organizations. It was important to include a wide range of partners in the planning process, each with their unique resources and experiences in planning, implementation and evaluation. The steering committee was charged with participating in a process by which all state partners could collaborate and advise DHSS on the tobacco use prevention strategic plan, priorities and implementation of the program with the overarching goal of reducing the health problems resulting from tobacco use in Missouri.

Philosophical Approach

The tobacco industry may be the foremost obstacle to changing the social norm of smoking.⁷ The industry has spent, and continues to spend, billions of dollars promoting images of freedom, independence, glamour, and thinness in order to sell a legal, yet potentially lethal, product that addicts the majority of its customers.

Early in the strategic planning process the steering committee made a key decision regarding the philosophical approach the Missouri tobacco use prevention effort would take to address tobacco control in order to realize its mission, vision and achieve its goals.

The steering committee reached consensus on recommending the following three-prong philosophical approach for Missouri's tobacco use prevention effort:

- 1. Assertively counter the tobacco industry's practices with pro-health messages;***
 - 2. Use accurate terminology to describe the effects of tobacco use and its highly addictive properties; and,***
 - 3. Create a comprehensive tobacco use prevention program that includes de-normalizing tobacco use.***
-

Strategic Directions

Three strategic directions were developed to assure that key strategies were selected for each goal to alter the social environment in which smoking and cessation occurs. It is well understood that to change tobacco use behaviors the efforts of entire communities are required to modify the way tobacco is promoted, sold and used. Additionally, community norms have to be refocused on the importance of comprehensive health and wellness for all individuals. Further, it was considered extremely important to identify and address the needs of populations disproportionately impacted by tobacco use as an intricate part of each goal. Therefore, the strategic directions developed to guide development of strategies for each goal and plan implementation were:

- Identify populations disproportionately impacted by tobacco and design ways to combat tobacco effects among those groups.
- Educate Missourians on the detrimental effects of tobacco use and the tobacco industry's practices in order to effectively de-normalize tobacco use in Missouri.
- Mobilize communities to effectively de-normalize tobacco use in Missouri.

Mission

The following mission statement was developed by the steering committee to define its shared purpose or “reason for being”:

“To promote health for all Missourians by eliminating exposure to secondhand smoke and significantly reducing tobacco use through comprehensive statewide and community programs.”

Vision

The following vision was developed by the steering committee and represents the future for Missouri that we are striving to make a reality:

“Missouri free from tobacco use, addiction and exposure to secondhand smoke.”

Guiding Principles

The guiding principles along with the mission and vision statements, Strengths-Weaknesses-Opportunities-Threats (SWOT) analysis, and information from the regional meetings laid the groundwork that guided decisions, formed the framework for effectively working with partners across the state, and served as a reference point for developing the strategic initiatives and strategies. The guiding principles set forth by the steering committee were:

- **Best practices, evidence-based strategies:** Provide vigilance regarding the use of evidence-based approaches to assure that intended results are achieved.
- **Measurement and accountability:** Support measurement and accountability practices that will evaluate impact and outcomes.
- **Conflict of interest:** Assure individuals, organizations and contractors have no conflict of interest regarding funding or ties with the tobacco industry.
- **Systems Approach:** Support a systems approach [to comprehensive tobacco use prevention] that is population-based.
- **Collaboration and coordination:** Promote the coordination and collaboration between state and local organizations and contractors.
- **Comprehensive program, sustainability:** Promote a long-term, comprehensive approach to tobacco prevention that emphasizes sustainability.
- **Diversity:** Assure the consideration of Missouri’s diverse populations to guide culturally-competent tobacco use prevention program.
- **Courage and integrity:** Consider the successful implementation of the statewide tobacco use prevention strategic plan includes both courage and integrity.

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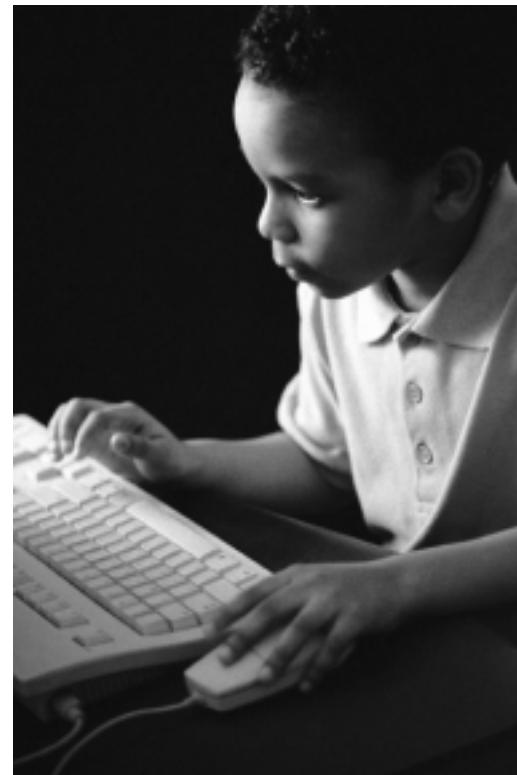
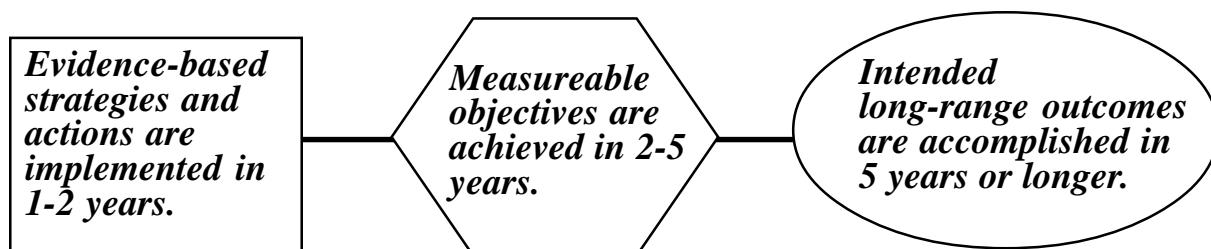
Program Goals, Outcomes, Objectives and Actions

A guiding principle of the Missouri Comprehensive Tobacco Use Prevention Program is to “provide vigilance regarding the use of evidence-based approaches to assure that intended results are achieved.” Evidence from programs in states that have successfully reduced tobacco use and its harmful effects, such as California and Massachusetts, has provided a “guidebook” for other states to follow in planning and implementing comprehensive programs. CDC Office on Smoking and Health issued “Best Practices for Comprehensive Tobacco Control Programs” in which goals, key components, and recommended activities for a comprehensive program were described. Additionally, the U.S. Task Force on Community Preventive Services issued a list of recommended evidence-based approaches for reducing tobacco use. The Missouri Statewide Tobacco Steering Committee reviewed the recommendations, as well as evidence-based approaches identified through a review of the research literature. As a result of the review, the following program goals were adopted.

- Prevent tobacco use initiation among young people.
- Promote quitting among young people and adults.
- Eliminate exposure to secondhand tobacco smoke.

Presented for each program goal are long-range outcomes to be achieved in five or more years, strategies and actions for each goal based on the evidence, and measurable objectives to gauge progress in accomplishing each strategy in the next two to five years. Sources of data are described elsewhere.

Plans for how the actions will be implemented are also described elsewhere. The relationship of the strategies, objectives and outcomes is best explained with the following logic model:



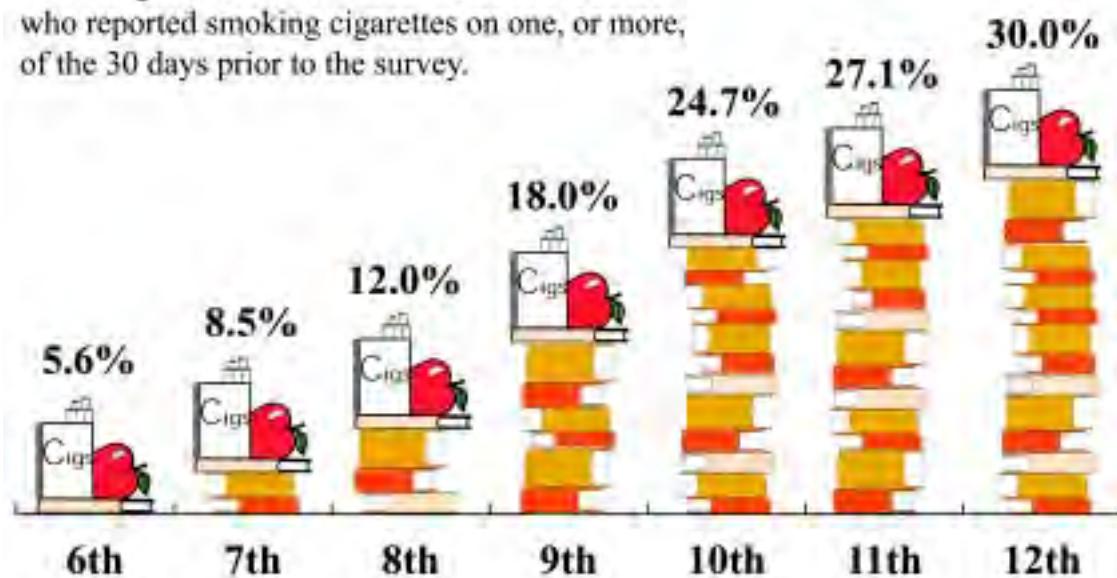
Goal 1: Prevent Tobacco Use Initiation Among Young People

Rationale:

Early adolescence (ages 11-15, grades 6-10) is the period when most smokers tried cigarettes for the first time. The majority of adult smokers progressed to become regular smokers before the age of 18. Influences on young people to smoke include having parents or guardians that smoke or having parents with less than a high school education. Young people who misperceive smoking prevalence among adults and their peers tend to acquire approval of smoking behavior and are more likely to become smokers. Additionally, adolescents are more likely to smoke if they associate it with pro-social outcomes, such as having a positive image and bonding with a peer group. Other factors that may influence young people to try smoking include the media glamorizing the behavior, particularly among young women who want to be thin and think smoking will help them control their weight.⁸

Current Missouri Youth Smoking Rates, Grades 6-12

Percentage of Missouri Public School Students who reported smoking cigarettes on one, or more, of the 30 days prior to the survey.



Source: Missouri Youth Tobacco Survey, June, 2003
Missouri Department of Health and Senior Services,
Jefferson City, Missouri

graph design by Jim McDonald
Missouri Tobacco Use Prevention Program
[WWW.DHSS.STATE.MO.US/SMOKINGANDTOBACCO](http://www.dhss.state.mo.us/SmokingAndTobacco)

Long-range Outcomes of Decreasing Initiation

- Decrease the percentage of students in grades 9-12 who first smoked a whole cigarette before the age of 13 from 22.7% (01 YRBS) to 16.7% by 2009.
- Decrease the percentage of students in grades 9-12 that smoked on one or more of the previous 30 days from 30.3 % (01 YRBS) to 18.6% by 2009.
- Decrease tobacco use among youth not in traditional school settings who use at disproportionately higher rates than young people their age. (No data are available)

Strategy – Increase the price of tobacco products

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Evidence:

Increasing the price of tobacco products is a highly effective and recommended intervention for reducing initiation of tobacco use by young people.⁸⁻¹⁰

Objectives:

1. Increase the per pack state tax on cigarettes from \$0.17 (2003) to \$0.72 and by 20% on other tobacco products by 2005.
2. Increase the percentage of adults who support increasing the tax on cigarettes if some or all the money were used for tobacco prevention programs from 60.7% (03 CLS) to 70.0% by November 2005.

Actions:

1. Increase awareness among the public and policy makers about the evidence that increasing the price of tobacco products decreases initiation and use among youth.
2. Create support among the public and policy makers that funding prevention programs for youth with tobacco tax proceeds will produce an even greater reduction in use and is therefore a wise investment.



***Strategy –
Increase pro-health
knowledge, beliefs and
skills among youth***

Evidence:

Increasing the knowledge, beliefs and skills of young people to recognize and resist

social influences to use tobacco, especially when combined with education to correct misperceptions about the prevalence of use, has been shown to decrease initiation of tobacco use among youth.^{8, 10-13} Mass media campaigns of an extended duration to inform and motivate young people to remain tobacco free are highly effective and strongly recommended when combined with other interventions.⁹

Objectives:

1. Increase the percentage of students in grades 6-12 that think tobacco is as addictive as heroin or cocaine from 90.2% of middle school and 87.9% of high school (03 YTS) to 92% overall by 2007.
2. Increase the percentage of students in grades 6-12 who have never smoked and think they will definitely not smoke a cigarette during the next year from 84.4% of middle school and 86.9% of high school (03 YTS) to 90% overall by 2007.
3. Increase the proportion of secondary schools (grades 6-12) that include in health courses making a personal commitment not to use tobacco from 70% (2000 SHEP) to 75% by 2006.
4. Increase the proportion of secondary schools (grades 6-12) that teach students how to influence or support others to prevent tobacco use from 89% (2000 SHEP) to 92% by 2006.
5. Increase the percentage of students in grades 6-12 that report participating in community activities to discourage peers from using tobacco products from 21.0% middle school and 14.1% high school (03 YTS) to 25% middle school and 20% high school by 2007.
6. Increase the number of youth not in traditional school settings that think tobacco is as addictive as heroin or cocaine (no data available).
7. Increase the number of youth not in traditional school settings that think they will not smoke in the next year (no data available).

Actions:

1. Encourage and assist schools to follow the CDC “Guidelines for School Health Programs to Prevent Tobacco Use and Addiction”¹⁴ that includes recommendations to teach about the negative consequences of tobacco use, social influences, peer norms, resistance skills, and to provide training for teachers.
2. Assist schools and communities with organizing and training youth groups to effectively educate the public and their peers about the practices and influences of the tobacco industry and counter with pro-health messages. Enhance existing youth groups’ effectiveness.
3. Identify effective messages for countering influences on youth to use tobacco and deliver messages through sustained earned and paid media campaigns.
4. Seek the assistance of community-based organizations and agencies serving youth not in traditional school settings to assess for tobacco use and implement tobacco use prevention programs and messages where appropriate.

Strategy –
Create
tobacco-free
environments**Evidence:**

Creating tobacco-free school and community environments as a strategy for reducing young peoples' exposure to tobacco-promoting images, and as part of a comprehensive approach for tobacco use prevention is recommended.^{8, 10, 11, 13} Current evidence is insufficient to determine if school policies prohibiting tobacco use on school grounds alone results in reduced initiation and use by youth.¹⁰

Objectives:

1. Increase the proportion of secondary schools (grades 6-12) that prohibit students from wearing tobacco clothing or carrying tobacco company merchandise from 92% (2000 SHEP) to 100% by 2006.
2. Increase the percentage of secondary schools that prohibit student smoking at off-campus, school sponsored events from 96% (2000 SHEP) to 100% by 2006.

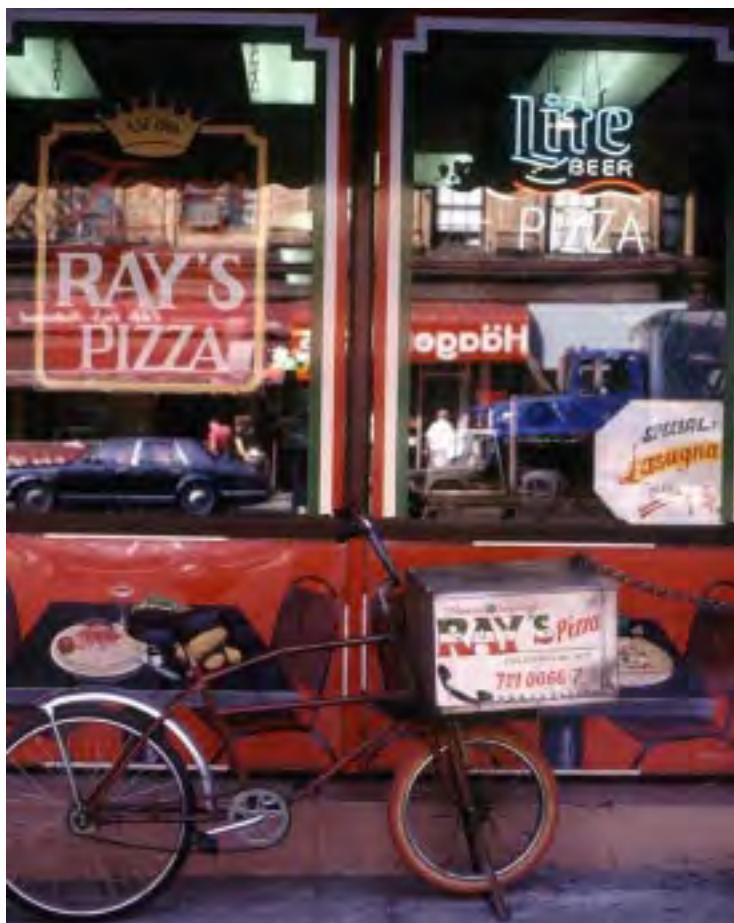
3. Increase the proportion of secondary schools that prohibit student use of smokeless tobacco (93%), cigars (90%) and pipes (89%) (2000 SHEP) to 100% for all tobacco products by 2006.
4. Increase the proportion of secondary schools that prohibit tobacco advertising: in buildings, on grounds, in buses (94%), in school publications (93%), or through sponsorship of school events (89%) to 100% for all advertising by 2006.
5. Increase the proportion of secondary schools that prohibit faculty and staff use of cigarettes (75%) and other forms of tobacco (70%) (2000 SHEP) on school property and at school-sponsored events to 100% for all tobacco products by 2006.
6. Increase the proportion of secondary schools that prohibit visitors from use of cigarettes (81%) (2002 SHEP), smokeless tobacco (75%), cigars (79%) and pipes (79%) on school property and at school-sponsored events to 100% for all forms of tobacco by 2006.
7. Increase communities that prohibit tobacco sponsorship of youth activities. (no data)

Actions:

1. Increase awareness among education and community officials of the benefits of creating tobacco-free environments for youth.
2. Encourage and assist schools to follow the CDC “Guidelines for School Health Programs to Prevent Tobacco Use and Addiction”⁶ that includes a recommendation to implement and enforce tobacco-free school policies.
3. Assist schools and communities with organizing and training youth groups to effectively advocate for tobacco-free school and community environments. Enhance existing groups’ effectiveness.

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***Strategy –
Decrease
youth access
to tobacco
products
through
retail sales***

Evidence:

Decreasing youth access to tobacco products through state and local laws prohibiting retail sales to minors is a recommended strategy as part of a comprehensive program for tobacco use prevention.^{8, 11} Current evidence is insufficient to determine if decreasing access of tobacco through retail sales to minors alone results in reduced initiation or use among youth.^{8, 10}

Objectives:

1. Decrease the percentage of high school students under the age of 18 who report buying cigarettes from a store in the past 30 days from 19.6% (2001 YRBS) to 15% by 2007.
2. Increase retailer compliance with no-sales-to-minors law from 89.0% (2002 DMH Synar) to 93.0% by 2006.

Actions:

1. Enhance retailer education about the state's no-sales-to-minors law.
2. Enhance enforcement of the state's no-sales-to-minors law.
3. Monitor legislation for attempts to preempt community efforts to prohibit sales of tobacco products to minors.

Goal 2: Promote Quitting Among Youth and Adults

Rationale:

“Programs that successfully assist young and adult smokers in quitting can produce a quicker and probably larger short-term public health benefit than any other component of a comprehensive tobacco control program.”

¹⁴ (pg.24) For smokers who quit before the age of 50, the risk of dying in the next 15 years is cut in half.¹⁶ Numerous studies have demonstrated the cost effectiveness of a variety of interventions that resulted in successful cessation among tobacco users.¹⁶ Smoking



cessation interventions are even more cost effective than other commonly provided clinical preventive services such as mammography, colon cancer screenings, PAP tests, and treatment of mild to moderate hypertension and high cholesterol. The cost savings from reduction of tobacco use as a result of implementing moderately priced, effective cessation interventions more than pay for themselves in three to four years.¹⁴

Long-range Outcomes of Quitting

- Decrease the percentage of adults who smoke cigarettes from 27.2% (00 BRFSS) to 14.5% by 2009.
- Decrease the percentage of students in grades 9-12 that smoked on one or more of the previous 30 days from 30.3% (2001 YRBS) to 18.6% by 2009.
- Decrease the percentage of pregnant females who smoke during pregnancy from 18.3% (2001 Birth records) to 13.5% by 2009.

Strategy – Increase the price of tobacco products

Evidence:

Increasing the price of tobacco products is a highly effective and recommended intervention for increasing quitting and reducing consumption among youth and adults.^{16,17} For each ten percent increase in the price of cigarettes, the overall consumption will decrease by three to five percent, even more among young people.¹⁶



Objectives:

1. Increase the per pack state tax on cigarettes from \$0.17 (2003) to \$0.72 and by 20 % on other tobacco products by 2005.
2. Increase the percentage of adults who support increasing the tax on cigarettes if some or all the money were used for tobacco prevention programs from 60.7% (03 CLS) to 70.0% by November 2005.

Actions:

1. Increase awareness among the public and policy makers about the evidence that increasing the price of tobacco products increases quitting among youth and adults.
2. Create support among the public and policy makers that funding cessation and prevention programs with tobacco tax proceeds will produce an even greater reduction in use and is therefore a wise investment.

Strategy – Promote quitting by adult and youth tobacco users

Evidence:

“Tobacco dependence may best be viewed as a chronic disease with remission and relapse.”¹⁶ (p. 134) Due to the addictive nature of nicotine, most people that stop smoking require multiple quit attempts and varying levels of interventions.¹⁶ Mass media campaigns of extended duration using brief, recurring messages informing and motivating users to quit are strongly recommended when combined with other interventions.¹⁷



Objectives:

1. Increase the percentage of adult smokers that quit for one day or longer during the past 12 months because they were trying to quit from 25.9% (01 BRFSS) to 28% by 2006.
2. Increase the percentage of adult smokers that are seriously considering stopping smoking within the next six months from 61.6% (03 CLS) to 65% by 2006.
3. Increase the percentage of adult smokers that are planning to stop smoking within the next 30 days from 26.1% (03 CLS) to 30.0% by 2006.
4. Increase the percentage of adult smokers that think they would be very, or somewhat, successful in stopping smoking if they tried from 48.3% (03 CLS) to 60.0% by 2006.
5. Increase the percentage of adult smokers that agree there are health benefits from quitting smoking, even after 20 years, from 80.7% (03 CLS) to 90.0% by 2006.
6. Increase the percentage of high school smokers that tried to quit smoking during the past 12 months from 59.8% (01 YRBS) to 75% by 2007.
7. Increase the percentage of high school smokers that want to stop smoking from 56.4% (03 YTS) to 60.0% by 2007.

Actions:

1. Conduct research to identify culturally appropriate effective messages to encourage tobacco users to quit.
2. Identify and counter tobacco industry messages that encourage certain population groups to use tobacco products.
3. Promote social supports for tobacco users to quit such as by encouraging family and friends to support users’ attempts to quit.

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Strategy – Increase health care provider counseling to tobacco users

Evidence:

Health care system interventions to prompt health care providers to assess for tobacco use and counsel users to quit are effective and strongly recommended.^{14, 16, 17} Health care providers counseling patients, including giving brief advice to quit, is effective and strongly recommended.^{14, 16, 17}



Objectives:

1. Increase the percentage of adult smokers that were asked by a doctor, nurse or other health professional if they smoked from 23.1% (03 CLS) to 30.0% by 2007.
2. Increase the percentage of adult smokers that were advised by a doctor, nurse or other health professional to quit smoking from 63.7% (03 CLS) to 70.0% by 2007.
3. Increase the percentage of adult smokers that were advised to quit smoking by a doctor, nurse or other health professional and also prescribed or recommended medications to help them quit from 35.5% (03 CLS) to 40.0% by 2007.
4. Increase the percentage of adult smokers that were advised to quit smoking by a doctor, nurse or health professional and were also encouraged to use a cessation program, quit line or counseling to help them quit from 14.7% (03 CLS) to 25.0% by 2007.
5. Increase the percentage of adult smokers that were advised by a dentist to quit smoking from 5.4% (03 CLS) to 10.0% by 2007.

Actions:

1. Encourage and assist health care systems to provide prompts for health care providers to assess for tobacco use, advise users to quit and refer for appropriate treatment.
2. Encourage health care providers to follow the “Treating Tobacco Use and Dependence” Clinical Practice Guidelines.¹⁸

**Strategy –
Increase available,
affordable and accessible
cessation services**

Evidence:

Pharmacological treatment of nicotine addiction (including the use of nicotine patch and gum) is effective and strongly recommended.^{14, 16, 17} Reducing patient out-of-pocket costs for effective cessation therapies is an effective and recommended strategy for reducing barriers for users that want to quit.^{14, 16, 17} Multi-component proactive patient telephone supports (e.g., Quit lines) are effective and strongly recommended when combined with other interventions, such as mass media campaigns and/or therapies.^{14, 17}



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Objectives:

1. Increase the percentage of current adult smokers that used some form of medication to help them stop smoking for one day or longer during the past 12 months from 14.3% (03 CLS) to 25% by 2007.
2. Increase the percentage of current adult smokers that sought assistance for quitting such as through classes or counseling from 2.8% (03 CLS) to 10.0% by 2007.
3. Increase the percentage of high school smokers that participated in a program to help them quit smoking from 6.8% (03 YTS) to 15.0% by 2007.

Actions:

1. Increase awareness among employers and insurance companies about the benefits of covering cessation services for employees that smoke and lowering insurance premium for non-tobacco using employees.
2. Create support among elected officials and policymakers that cessation services are a good investment.
3. Investigate and encourage cessation service coverage by large health insurance providers including Medicaid, Medicare and Missouri Consolidated Health Plan for state employees, to reduce out-of-pocket costs of services for smokers that want to quit.
4. Collaborate with the Centers for Disease Control and Prevention Office on Smoking and Health, the American Legacy Foundation and other states to explore avenues for supporting a multi-state cessation proactive quit-line counseling service.

Goal 3: Decrease Exposure to Secondhand (Environmental) Tobacco Smoke

Rationale:

In 1986, the U.S. Surgeon General concluded that involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers. The report also found that children of smoking parents have an increased incidence of respiratory infections. A comprehensive review of the respiratory effects of secondhand environmental tobacco smoke (ETS) by the Environmental Protection Agency (EPA) in 1992 stated that ETS is a human lung carcinogen causing 3,000 lung cancer deaths each year among adult nonsmokers in the United States. Secondhand smoke also causes bronchitis, pneumonia, middle ear infections and asthma among children.¹⁹ Secondhand smoke is the third leading cause of preventable death in the United States, causing more than 53,000 nonsmokers to die each year.² State and local laws, as well as case law, require employers to protect the health of workers. Courts have ruled that employers must provide nonsmoking employees protection from proven health hazards of ETS exposure. The EPA estimates that if employers nationwide implemented clean indoor air policies to eliminate smoking in the workplace, \$4 to \$8 billion would be saved in lost productivity, absenteeism, health insurance costs, fire risk, and building cleaning and maintenance costs.¹⁹

Long-range Outcomes for Decreasing Secondhand Smoke Exposure

- Decrease the percentage of adults who work indoors that are exposed to tobacco smoke in their work area from 17.7% (03 CLS) to 8.0% by 2009.
- Decrease the percentage of students in grades 6-12 who have never smoked that during the past seven days were in the same room with someone smoking cigarettes from 53.7% middle school and 52.6% high school (03 YTS) to 48% overall by 2009.
- Increase the proportion of Missouri municipalities with populations greater than 1,000 that have ordinances restricting smoking in privately owned public places from 13% (98 DHSS study) to 20.0% by 2009.
- Increase the proportion of Missouri municipalities with populations greater than 1,000 that have ordinances restricting smoking in city-owned buildings and facilities beyond that required by the state clean indoor air law from 20% (98 DHSS study) to 25.0% by 2009.

Strategy –
***Increase awareness
of the health and
economic costs of
exposure to
secondhand smoke***



Evidence:

Although considerable evidence exists about the health and economic costs of exposure to secondhand smoke, most adults report exposure to other people's cigarette smoke is an "annoyance". The workplace and the home are the primary sources of secondhand smoke exposure among nonsmokers.¹⁹ Employees working in workplaces with the least restrictive policies (e.g., service workers in bars and restaurants) are exposed at disproportionately higher levels of secondhand smoke. Secondhand smoke in restaurants is approximately 1.6 to 2.0 higher than in office workplaces, and 4 to 6 times greater in bars.²¹ Increasing awareness of the health and economic effects of exposure to secondhand smoke is a recommended strategy for reducing exposure to secondhand smoke.^{22, 23}

Objectives:

1. Increase the percentage of adults who believe breathing smoke from other people's cigarettes is very, or somewhat, harmful from 93.4% (03 CLS) to 97% by 2007.
2. Increase the percentage of adults who in the past 12 months asked a stranger not to smoke around them from 16.2% (03 CLS) to 25.0% by 2007.
3. Increase the percentage of adults who report smoking is not allowed in their homes from 58.8% (03 CLS) to 62.0% by 2007.
4. Increase the percentage of adults who report smoking is not allowed in their cars from 53.9% (03 CLS) to 58.0% by 2007.
5. Increase the percentage of youth in grades 6-12 who think that smoke from other people's cigarettes is definitely or probably harmful from 91.3% middle school and 92.5% high school (03 YTS) to 95.0% overall by 2007.

**Actions:**

1. Increase awareness among the public, elected officials, policymakers, and employers of the economic and health effects of secondhand smoke exposure, challenging the perceived norm that exposure to others' tobacco smoke is not merely an annoyance but a health hazard.
2. Identify groups disproportionately impacted by exposure to secondhand tobacco smoke and develop messages to educate the public, policymakers, and employers about the health effects experienced by these groups.

Strategy –
Increase support for policies that prohibit smoking in public places

Evidence:

Enforced laws and ordinances that prohibit smoking in worksites, public buildings, and other public places are highly effective in reducing nonsmokers' exposure to secondhand smoke, and are strongly recommended.^{19, 23, 24}



Objectives:

1. Increase the percentage of adults who would support a law in their community that would eliminate all tobacco smoke from restaurants from 65.1% (03 CLS) to 75% by 2007.
2. Increase the percentage of adults who think smoking should not be allowed at all in:
 - a. Restaurants from 49.7% (03 CLS) to 60.0% by 2007.
 - b. Indoor shopping malls from 60.2% (03 CLS) to 70.0% by 2007.
 - c. Public buildings from 59.7% (03 CLS) to 70.0% by 2007.
 - d. Bars and cocktail lounges from 25.0% (03 CLS) to 30.0% by 2007.
 - e. Indoor sporting events and concerts from 62.0% (03 CLS) to 70.0% by 2007.
3. Increase the number of public places (restaurants, workplaces, and other) that voluntarily prohibit smoking from 668 in 8 municipalities (02 DHSS program data) to 1,000 in 12 municipalities by 2007.
4. Increase the number of community coalitions whose top priority is to reduce exposure of secondhand smoke from 11 (02 DHSS survey) to 20 by 2007.

Actions:

1. Increase awareness among the public, elected officials, local law enforcement, and employers about the need to enforce existing state and local clean indoor air laws.
2. Enhance community capacity for establishing and enforcing clean indoor air policies and ordinances by providing resources and training for new and existing coalitions.
3. Identify and counter arguments against clean indoor air policies and ordinances, such as the perceived loss of customers by businesses that prohibit smoking.
4. Establish a statewide tracking system for clean indoor air policies and ordinances adopted in communities.
5. Monitor state and local legislation for attempts to preempt adoption of clean indoor air policies and ordinances.

Strategic Plan Implementation and Accountability Process

Implementation of the strategic plan will be accomplished through a coordinated action planning effort by state and local tobacco control partners. The partners will identify strategies and actions that each can implement through respective programs in their organizations and agencies. Action plans will be developed on an annual basis and progress in accomplishing the actions will be tracked.

The Missouri Department of Health and Senior Services, Division of Chronic Disease Prevention and Health Promotion will implement a surveillance and evaluation plan to track progress in meeting program strategies and objectives. Letters of commitment will be requested from each partner organization to ensure accountability in achieving the actions outlined in the plan.

Communication among partners will be facilitated through regular meetings or conference calls to ensure program coordination, sharing of information and successes, and resolution of problems that may be encountered in the implementation process. Progress will be reported by each partner organization at meetings of the statewide Steering Committee.

Evaluation:

Providing a strong evaluation can be beneficial in managing and implementing a comprehensive plan, improving performance through data-based planning and helping to demonstrate accountability. Surveillance and evaluation data will form the basis for baseline measures, document the project's outcomes and successes, show that funds are being spent appropriately, and enable staff to identify effective approaches to continue so that resources are not wasted on ineffective interventions.

Evaluation will consist of process, short-term, intermediate and long-term outcome evaluations. Process evaluation will evaluate implementation of interventions, population groups reached, program operations and effectiveness of local grants and contracts. Short-term and intermediate indicator evaluations will monitor changes in awareness, knowledge, attitudes, beliefs, skills, social norms and policies related to tobacco use prevention and control. Long-term outcome evaluation will consist of determining progress regarding health behaviors and overall changes in the population's health status (e.g., morbidity, mortality and health care costs).

Plans for securing funding for implementation of the plan:

To fully and effectively implement the comprehensive tobacco use prevention strategic plan, resources must be secured to augment those currently received from the Centers for Disease Control and Prevention, and other federal and private funders. Efforts will continue to secure state resources from tobacco Master Settlement Agreement (MSA) funds and proceeds from taxes on tobacco products. Additionally, securing resources from private sources, such as foundations, will be pursued. A plan to stage implementation of a comprehensive program based on available funding is outlined on the following pages. As increased funding is secured, additional program components and expanded services will be possible. [The Centers for Disease Control and Prevention (CDC) estimates that Missouri's annual cost of an effective, comprehensive tobacco prevention program would range from \$32.8 million to \$91.4 million.⁶]

<u>Funding level</u>	<u>Program support</u>
\$6 million	<ul style="list-style-type: none"> ● Grants to 115 counties and cities to support community efforts to educate about health hazards of secondhand smoke and encourage adoption of policies to prohibit smoking in both work and public places ● Training and resources for communities on evidence-based strategies ● Contract to plan evaluation of community efforts ● Collaborative multi-state telephone counseling support for smokers and limited paid media to promote its availability ● Contract to plan evaluation of Quitline counseling service ● Identify groups disproportionately impacted by tobacco use and secondhand smoke exposure (e.g., pregnant women and infants; youth; low socioeconomic) and messages to reach populations
\$8 million	<ul style="list-style-type: none"> ● Continue grants to 115 counties and cities to support community efforts in clean indoor air initiatives; evaluate efforts ● Additional training and resources for communities ● Paid media to support community efforts in clean indoor air ● Fund approximately 25 community based organizations and/or schools for pilot programs with groups disproportionately impacted by tobacco ● Contract for feasibility study for Medicaid coverage of cessation services, including pharmacotherapies ● Contract to refine culturally appropriate media messages to motivate smokers to quit; expanded quit line services and paid media to promote Quitline availability statewide; continue contract to evaluate service
\$10 million	<ul style="list-style-type: none"> ● Expand county/city grants to include planning a comprehensive approach for addressing tobacco use prevention and quitting, and chronic disease care management involving health care systems, schools, community-based organizations, and others. ● Continue training, resource and media support and evaluation of community efforts to increase local policies prohibiting smoking in both work and public places ● Continue community-based projects and evaluation; and connect with comprehensive community approaches ● Continue Quitline service; media and evaluation ● Pilot, for select geographic area, Medicaid coverage of cessation services, including pharmacotherapies ● Replicate 2002-03 county-level survey of adult tobacco use and perceptions

Funding level	Program support
\$20 million	<ul style="list-style-type: none"> ● Grants to counties and cities increased to support comprehensive approaches for tobacco use prevention and quitting; and chronic disease care management ● Contracts to provide a variety of training and resources for community programs; evaluate community programs ● Expand Medicaid coverage of cessation services and pharmacotherapies ● Expand paid media to motivate smokers to quit; promote availability of Medicaid supported services, and continuation of Quitline services ● Contract to evaluate quit strategies and services
\$33 million	<ul style="list-style-type: none"> ● Expand local programs' funding ● Expand coverage of Medicaid support for cessation services and pharmacotherapies ● Continue Quitline service ● Expand media campaign; evaluation ● Contract for independent evaluation of program
\$50 million	<ul style="list-style-type: none"> ● Expand local programs' funding ● Expand coverage of Medicaid support for cessation services and pharmacotherapies ● Continue Quitline service ● Expand media campaign; evaluation ● Contract for independent evaluation of program
\$65 million	<ul style="list-style-type: none"> ● Continue local program funding ● Full coverage of Medicaid support for cessation services and pharmacotherapies ● Expand local programs' funding ● Continue Quitline service ● Expand media campaign; evaluation ● Contract for independent evaluation of program

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Appendix A

The Strategic Planning Process

The initial meeting of the steering committee was held in March 2002 and focused on a general orientation and education about what has worked in other states. The planning process centered on answering the following three questions about Missouri's statewide prevention effort:

1. Who are we?
2. Where are we going?
3. How are we going to get there?

A series of meetings were held with the steering committee from September through December to address the three planning questions as they pertained to Missouri's statewide tobacco prevention effort. These efforts were facilitated by Dewey and Associates. The key activities and a summary of the results from each activity follow.

- *Partner and Stakeholder Study* - A survey was conducted with steering committee members and other key stakeholders to examine tobacco prevention programs in Missouri and obtain an understanding of their attitudes and opinions regarding the development and direction of the strategic plan. A majority of the respondents understood what a comprehensive tobacco prevention program entailed and wanted to see all the components included in the program.
- *Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis* - The steering committee identified the strengths, weaknesses, opportunities and threats of a statewide effort to measurably reduce tobacco use. The key strengths of a statewide tobacco use prevention effort identified by the steering committee were the impressive existing partnership and commitment to combat tobacco use, a strong strategic planning process and being able to benefit from the best practices and successes in other states. The major weaknesses and threats perceived by the steering committee were the tolerance of tobacco use from a large majority of the population, the strong presence of the tobacco industry in the state and the budget crisis currently faced by the state.
- *Regional Meetings* - During October 2002, DHSS hosted a series of six regional meetings across the state to gain public input on the state's strategic plan for tobacco use prevention. The meetings were held in St. Louis, Poplar Bluff, Springfield, Jefferson City, Macon and Kansas City. The key findings of the public meetings were:
 - Some noticeable differences in terms of the acceptability of particular strategic approaches based on geography. For instance, all communities wanted a counter-marketing campaign to support their local tobacco use prevention efforts, but there were differences on how strong and what messages would be acceptable.
 - Smoke-free campuses, school-based programs and raising the cost of tobacco as part of a comprehensive plan were frequently cited as important strategies.

These key findings added value to the planning process, provided new ideas for consideration, and represented a strong endorsement of the steering committee's strategic thinking and the need to embrace a range of approaches in order to address diverse needs of Missouri's distinct regions.

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Data Sources

CLS – (County-Level Study) Telephone survey of approximately 15,000 randomly selected adults over the age of 18 conducted for the first time in 2002-2003 by the DHSS.

BRFSS – (Behavioral Risk Factor Surveillance System) Annual telephone survey of randomly selected adults over the age of 18 conducted by the DHSS.

SHEP – (School Health Education Profile) Survey of randomly selected public middle and high school (grades 6-12) principals and lead health education teachers conducted every even-numbered spring since 1994 by the Department of Elementary & Secondary Education.

YRBS – (Youth Risk Behavior Survey) Survey of randomly selected public high school students (grades 9-12) conducted every odd-numbered spring since 1995 by the Department of Elementary & Secondary Education.

2001 Missouri YRBS N = 1,650.

YTS – (Youth Tobacco Survey) Survey of randomly selected public middle and high school students (grades 6-12) conducted for the first time in 2003 by the DHSS.

DMH Synar report – Report of retailer compliance with law prohibiting tobacco sales to minors completed annually by the Department of Mental Health Division of Alcohol and Drug Abuse.

Birth records – Data obtained from health care providers at the time of issuing a birth certificate for newborns.

DHSS program data – Information obtained from local programs in 2002.

DHSS survey – (2002) Special survey of community coalitions in the state (N=36).

Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan 2003—2009



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